MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
PRESCRIPTION DRUG REPOSITORY PROGRAM

DONATED DRUG OWNERSHIP RECORD

NAME OF REPOSITORY SITE	ADDRESS OF REPOSITORY SITE	TELEPHONE NUMBER

DONATED PRESCRIPTION DRUG INFORMATION

DRUG NAME	STRENGTH	MANUFACTURER	NDC (IF AVAILABLE)	LOT NUMBER	QUANTITY

DONOR INFORMATION

I am the owner of these drugs and I intend to voluntarily donate them to the Prescription Drug Repository Program. I certify that the donated drug(s) has (have) been stored according to manufacturer and/or USP requirements.

NAME OF OWNER OF DRUG(S) (PRINT OR TYPE)	SIGNATURE OF OWNER OR REPRESENTATIVE
TITLE/RELATIONSHIP OF REPRESENTATIVE	DATE

I have inspected the donated drug(s) listed above and determined that they are safe and suitable for dispensing, the drug(s) and the packaging are in compliance with 19 CSR 20-50.025, and there are no controlled substances or drugs that require storage temperatures other than normal room temperature as specified by the manufacturer and/or USP.

SIGNATURE OF REPOSITORY SITE REPRESENTATIVE	DATE